Evidence Based Practice Indicators for Alcohol and Other Drug Interventions

Summary

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Best Practice in Alcohol and Other Drug Interventions Working Group

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Web Document
This document is available online
http://www.wa.gov.au/drugwestaus/

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List of abbreviations and acronyms

AA	Alcoholics Anonymous
ADCU	Alcohol and Drug Coordination Unit (WA Police Service)
AOD	Alcohol and other drugs
BWSQ	Benzodiazepine Withdrawal Symptom Questionnaire
CALD	Culturally and linguistically diverse
CBT	Cognitive behavioural therapy
CCN	Cannabis Caution Notice
CCMES	Cannabis Cautioning and Mandatory Education System
CDST	Community Drug Service Team
CES-D	Centre for Epidemiological Studies Depression Scale
CNS	Central nervous system
COAG	Council of Australian Governments
DPP	Director of Public Prosecutions
DTs	Delirium tremens
GHQ	General Health Questionnaire
LAAM	Levo alpha acetylmethadol
MOJ	Ministry of Justice
NA	Narcotics Anonymous
OTI	Opiate Treatment Index
PBS	Pharmaceutical Benefits Scheme
PTSD	Post Traumatic Stress Disorder
SADQ-C	Severeity of Alcohol Dependence Questionnaire
SDS	Severity of Dependence Scale
SES	Self Esteem Scale
TGA	Therapeutic Goods Administration
WADASO	West Australian Drug Abuse Strategy Office
WAPS	West Australian Police Service

Foreword

The Western Australian Strategy Against Drug Abuse action plan for 1999-2001, *Together Against Drugs*, anticipates that:

> *"Health and community support services will continue to improve outcomes through the promotion and adoption of evidence based practice treatment interventions."*

Evidence based practice derives from a review of the literature and consultation with professionals in the alcohol and drug field. As such, the term evidence based practice encompasses best practice.

This document is one in a series of three, comprising:

- A Literature Review for Evidence Based Practice Indicators for Alcohol and other Drug Interventions.
- A Summary of the Evidence Based Practice Indicators for Alcohol and other Drug Interventions.
- A Guide for Counsellors Working with Alcohol and other Drug Users (Core Counselling Skills).

These documents identify current best practice and promote quality outcomes for clients. Their purpose is to support development of consistent, high quality service delivery.

The ***Summary of the Evidence Based Practice Indicators for Alcohol and other Drug Interventions*** informs contracts for service as well as service delivery in Western Australian agencies.

Both managers and counsellors can use this document as a reference, an educational tool and as an aid to quality management and professional supervision. The best practice indicators will be revised on a regular basis to assist service providers to keep up to date with advances in clinical practice and service delivery.

September 2000

Basic Elements of Treatment

1. General counselling approach

As part of the general counselling approach, counsellors should consider the following:

- Supportive and empathic counselling is a sound base.
- Counselling is a joint approach between the counsellor and client with treatment plans negotiated by and agreed upon by both parties.
- Therapeutic orientation is not as important as the therapeutic relationship.
- Therapeutic relationship is the most active ingredient in change.
- Clear case and progress notes should be maintained.
- Slowly drawing therapy to a conclusion by spreading out final sessions (reducing contact from once per week, to once per fortnight, once per month etc).
- Professional development is an important aspect of general counselling.

General counselling should include:

- Linking clients with appropriate services whilst client is still engaged.
- Anticipating and developing strategies with the client to cope with difficulties before they arise.
- Specific evidenced based interventions where appropriate (eg goal setting, motivational interview, problems solving etc).
- Focus on positive internal and external resources and successes as well as problems and disabilities.
- Where appropriate, involve a key supportive other to improve the possibility of behavioural change outside the therapeutic environment.

The counselling approach should reflect the findings of the treatment matching literature and research regarding the most appropriate global intervention strategy given the client's goals, assessment results and population type (minority group, presence of comorbid disorder, cognitive damage etc).

2. Program content

Counsellors need to look at the wider context of clients' lives, as focusing purely on drug related issues is rarely sufficient to produce enduring change. Working at an individual level should include the utilisation of a range of techniques. Specific cognitive behavioural therapy interventions should be included. They are:

- *goal setting* gives therapy a direction, provides a standard by which progress can be reviewed and gives clients concrete evidence of their improvement;
- *motivational interviewing and decision making* are useful strategies for those clients with ambivalence about changing their behaviour (this is done by encouraging the client to consider the good and not so good aspects about drug use);
- *problem solving* using a variety of techniques such as verbal instruction, written information and skill rehearsal; and
- *relapse prevention and management strategies* encompass cognitive behavioural strategies that provide clients with skills and the confidence to avoid and deal with any lapses (this often involves exploration of high-risk situations, mood, thoughts, places, people, situations, and events).

Program content should:

- address non drug use difficulties or issues raised in the assessment process where appropriate;
- respect treatment matching information and evidence based practice in regard to population groups, but be flexible enough to incorporate the needs of the individual and their goals; and
- link clients to other social services and support networks (such as medical services, housing assistance, parenting classes, employment and recreation services) when required. Agencies should have the necessary pathway and partnerships established.

Non residential and residential treatment services should have a program that includes:

- individual and group therapy;
- stress management;
- social, occupational and assertiveness skills training;
- relapse prevention and management; and
- exploration of harm reduction strategies.

3. Assessment

Research does not support the distinction between alcohol and other drug services in terms of assessment. Assessment procedures are the same irrespective of drug type. When performing an assessment, counsellors should consider the following.

- Upon entry into a treatment program clients should undergo informal and formal assessment. This is important for clients attending individual treatment or intensive group work sessions.
- Information gained from formal and informal assessments should be used as a foundation of an individual's tailored treatment program.
- All clients should be provided with a rationale for the assessment procedures.

3.1 Informal

An informal assessment should complement and provide a background for formal assessment. Informal assessment should include the following.

- Background and personal history (family composition and history, childhood experiences, adolescent experiences, experiences of school, occupational history, sexual/marital adjustment, legal issues, financial and housing information, leisure pursuits and risk taking behaviours).
- Support networks.
- Suicidal ideation.
- Strengths/weaknesses.
- Significant medical issues.
- Drug use history.
- Readiness to change.

Counsellors are not expected to assess cognitive functioning and mental/emotional health. If they suspect impairment in either of these areas, referral should be sought.

3.2 Standardised

Standardised assessment should complement informal assessment by providing support for tentative hypotheses and highlighting important issues that may not have been uncovered previously. Counsellors should be trained to use and interpret formal assessment instruments as appropriate. The standardised assessment tools recommended are:

- *Severity of Dependence Scale (SDS)* can be used to assess psychological dependence on any drug and complements the information on quantity and frequency on drug use obtained from the client;

- *Opiate Treatment Index (OTI)* is most appropriate for opiate users however it can be used for all drugs including alcohol;
- *Severity of Alcohol Dependence Questionnaire - Community Version (SADQ-C)* is to be given to clients who have a prolonged and extensive history of alcohol use and should be used to guide the need for inpatient detoxification and/or medical referral; and
- *Benzodiazepine Withdrawal Symptom Questionnaire (BWSQ)* is used to assess the severity of benzodiazepine withdrawal symptoms and should be given to clients with a suspected benzodiazepine dependence (as indicated by the SDS).

3.3 Feedback

After completion of assessment procedures, results are to be interpreted in relation to the client's personal history.

- Results of all assessment procedures to be fed back to all clients.
- Feedback is to include exploration of strengths, then weaknesses, without using labels and in terms appropriate for the client.

4. Treatment matching

The fundamental purpose of assessment should be to match the individual client to the appropriate treatment intervention. In treatment matching the following factors need to be considered:

- severity of dependence;
- gender and cultural issues;
- cognitive factors;
- support networks;
- life problems; and
- client choice.

When matching clients to the appropriate treatment intervention, the following is recommended.

- Clients with a higher degree of dependence should be encouraged to engage in more intensive programs that help to develop a social network not supportive of drinking or drug using.
- Residential treatment programs are more strongly indicated for clients with a lack of stable housing or primary relationships, and those clients with a support network supportive of continued using.
- If a client has a support base encouraging continued drinking or drug using, it is recommended that they attend at least 3 sessions of Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) in order to assess its appropriateness.
- Clients with high levels of anger respond better to motivational enhancement treatment.
- Behaviourally based treatments are the treatment of choice for cognitively damaged or intellectually impaired clients.
- Methadone maintenance treatment has been found to be effective for long term users with severe opiate dependence.
- Naltrexone maintenance treatment has been found to be effective for clients who place greater importance on ceasing use and for those who have networks supportive of ceasing use.
- Other pharmacotherapies, such as buprenorphine and LAAM, should also be considered as they become available.

5. Treatment plans

Treatment plans should be:

- well developed, articulated, written, detailed and clear;
- agreed on as the road map for therapy by both client and counsellor;
- directly derived from results of assessment, goal setting and client choice;
- contain practical, realistic goals and the strategies for achieving these goals; and
- where appropriate, include parents, partners, families and friends.

Treatment plans should contain:

- a review of the individual's current situation;
- an assessment of individual's strengths and needs;
- an assessment of the constraints and opportunities for meeting needs and objectives and practical strategies for achieving these;
- an assessment of the support needs for the individual to achieve desired objectives;
- methods of recording progress; and
- methods for evaluating outcome (refer to ***Outcome performance indicators*** on page 17).

6. Goals of intervention

Goals should be negotiated and should be:

- client directed;
- respectful of client's stage of change;
- clear;
- realistic and achievable; and
- overall treatment goals to be broken down into their smallest components.

Goals should include:

- reduction in drug use;
- improved physical health;
- improved psychological health;
- improved social adjustment and functioning;
- reduction in harm associated with drug use; and
- reduction in criminal behaviour.

7. Harm reduction

Harm reduction strategies are appropriate for clients who continue to use alcohol and/or other drugs, or who are likely to relapse. Strategies aim to reduce the harm associated with drinking/drug use, such as:

- overdose (eg avoid mixing drugs, using alone, etc);
- family violence (eg not to use when you are feeling angry or aggressive, sobering up shelters or to have an escape plan for potential victims of family violence, etc);
- driving under the influence of alcohol and other drugs (eg think about alternative methods of transport, etc); and
- blood borne viruses (eg use clean injecting equipment, etc).

In determining harm reduction strategies, attention should be given to:

- understanding the functions and problems of drug use;
- potential drug using/drinking harms can fall into categories such as problems of intoxication, problems of regular use and problems of dependence or 'liver, lover, livelihood, law'; and
- potential risks of polydrug use and the interactions of different drugs.

8. Case management

Family and Children's Services (1998) defines case management as the process that oversees or directs the administration, planning, coordination and delivery of services to clients by the case worker/case manager and/or by other workers.

Case management is a useful intervention model for working with substance users. It offers the client a single point of contact with health and social services, is driven by client need, involves advocacy, is community based, pragmatic, anticipatory, flexible and sensitive to culture and gender.

When adopting a case management approach, it is recommended the counsellor:

- identify clients' treatment and service needs;
- locate service options;
- link clients with appropriate services;
- monitor clients' progress in treatment; and
- evaluate services provided to clients.

Effective primary and combined case management involves the following.

- Clear and open communication between the professionals involved.
- Clarification of the requirements and boundaries of each specialist, which includes what will be communicated to and by the case manager (or team).
- Knowledge of other professionals involved and the nature of their involvement in the case.
- Having a contract (written or verbal) that outlines the expectations and boundaries of service provision, methods for ensuring continuity of services during staff turnover, clear lines of authority and control over various aspects of the case management process, a formal record of agencies agreements and responsibilities.

9. Information and advisory services

It is important that agencies and counsellors possess information and resources that are up to date and objective. Specific information services need to be readily accessible and attuned to the individual needs of the person using the service.

10. Follow up as part of treatment

The notion of the importance of follow up to improved outcomes for the client has been acknowledged in the literature. Despite the difficulties of following up clients, mainly due to the transient nature of this population, the practice of follow up has great utility as it can provide useful information regarding treatment efficacy, effective components of treatment and relapse rates.

Regarding follow up it is recommended the following be considered.

- Despite the difficulties of following up many drug using clients, follow up procedures be conducted as a priority.
- Follow up should be arranged within one to three months at the conclusion of treatment.
- Preference should be given to face to face (individual or group) or telephone contact, however written contact has benefit.
- The importance of, and format for, follow up procedures should be explained to clients prior to discharge. Clients should be given the option to participate in follow up.
- The follow up session should be scheduled prior to the client leaving the program.
- Clients should be followed up (where possible) regardless of whether they have relapsed.
- Follow up procedures should offer continued support, referral to another service, referral to self help groups or re-engagement in the program where appropriate.

Treatment modes

11. Brief intervention

Research indicates brief interventions are an appropriate response to clients presenting at a general health setting and who are unlikely to seek or attend specialist treatment. Brief intervention is appropriate when contact time and/or resources are limited. Brief intervention can range from one to five contacts.

Brief intervention is recommended for clients with:

- a low to moderate dependence on alcohol;
- a dependence on nicotine; or
- a low to moderate dependence on cannabis.

If brief intervention consists of only one session, it should include:

- advice on how to reduce drug use or drinking to a safer level;
- the provision of harm reduction information; and
- discussion of harm reduction strategies.

Multiple sessions could include:

- assessment of dependence;
- motivational intervention;
- goal setting; and
- assessment of high risk situations.

12. Detoxification

Attention should be given to the following.

- Detoxification may be undertaken at home, as an outpatient or in a residential or hospital setting.
- Detoxification may be with or without medication depending on the severity of dependence and/or client choice.
- Clients often do not wish to detoxify from all substances at once.
- Medication regimes are well established for most drugs of dependence.
- Where appropriate, detoxification should be a gateway to further treatment, including a link to ongoing treatment services or relapse prevention pharmacotherapies. Commitment to ongoing counselling must not be a pre requisite for admission to a detoxification program.
- Non using significant others should be engaged as supports.
- Pregnant women should be referred to a specialist drug and alcohol service or obstetric service.

12.1 Alcohol

The following treatment modes are recommended for clients considering detoxification from alcohol.

- *Residential* detoxification is indicated for clients with a history of moderate to severe withdrawal symptoms, the probability of severe withdrawal syndrome, serious concurrent physical or psychiatric disorders or a lack of non drinking social support.
- *Outpatient* detoxification is indicated for clients with mild to moderate withdrawal symptoms, no history of delerium tremens or withdrawal fits and the existence of a non drinking significant other, support or encouragement.

12.2 Benzodiazepines

For clients considering detoxification from benzodiazepines, counsellors should consider engaging the services of a doctor to assist in gradual withdrawal regime. Sudden cessation of benzodiazepines should be discouraged as relapse and other associated problems are very likely.

12.3 Opiates

For clients considering detoxification from opiates, counsellors should consider the following.

- Although many persons dependent on illicit drugs will have experienced some drug withdrawal without support, a supportive stable home environment will enhance successful home detoxification.
- Clients on methadone maintenance treatment and benzodiazepines should not be encouraged to withdraw from both substances at same time.
- Clients should not be encouraged to withdraw from methadone if it is against their wishes. Withdrawal should be discussed with the methadone prescribing doctor.
- Relapse is a common feature in both home and outpatient detoxification if strong support and supervision are not an integral component of this approach.

13. Residential treatment services

Residential programs should be broad based and include:

- the facilitation of access to medical facilities;
- employment, education and skills training;
- life skills training (cooking, budgeting etc);
- parenting skills training;
- entry into non drug using community groups and activities of interest, psychiatric facilities and legal services (where appropriate); and
- a reintegration program.

13.1 Alcohol

Research evidence does not indicate different outcomes for residential and non residential treatment for alcohol dependence. However, there is evidence to suggest that residential treatment is appropriate for alcohol dependence where the client:

- requires close supervision during detoxification;
- has severe alcohol related brain damage;
- shows severe deterioration, malnourishment or social instability;
- has repeatedly relapsed following treatment; and
- has social networks that are supportive of continued drinking.

13.2 Other drugs

There is no evidence regarding the relative effectiveness of residential and non residential treatment for other types of addictive disorders. However, there is general agreement that residential treatment for other drug dependence is appropriate for severely impaired client populations, including:

- dysfunctional and long term users who suffer significant harms from use; and
- users whose social networks are supportive of continued drug use.

There is some evidence to suggest that therapeutic communities may offer an effective form of treatment for drug users who find them acceptable.

14. Pharmacotherapies for dependence

The literature indicates that pharmacotherapies should not be seen as stand alone treatments but used in conjunction with other treatment components such as counselling.

14.1 Pharmacotherapies for opioid dependence

14.1.1 Methadone

Methadone is used as a maintenance treatment to stabilise opiate use. Methadone[1] is approved by the Therapeutic Goods Administration (TGA). Methadone is not listed on the Pharmaceutical Benefits Scheme (PBS).

Methadone is associated with the following:

- a reduction in illicit opioid use;
- a reduction in crime;
- improved social and occupational functioning where treatment is viewed as a long term commitment to stabilising lifestyle, relationships and change in drug taking behaviour;
- higher treatment retention rates; and
- a reduction in related risk behaviours.

Methadone treatment is indicated for opiate users who:

- have an established history of dependence;
- have attempted to give up a number of times;
- are heavily involved in the drug using lifestyle (unemployed, few non using friends, engaged in crime, dealing);
- engage in behaviours that increase the risk of blood borne virus (HIV, hepatitis B and C); and
- are pregnant.

Counsellors should be aware that methadone treatment tends to be more successful when:

- prescribed within a range between 60 – 80 mg daily (a dosage of <100mg is not associated with intoxication or lethargy); and
- where maintenance treatment is provided over extended periods of time (2 to 3 years).

When considering withdrawal from methadone, counsellors should be aware of the following.

- The long acting nature of methadone requires reduction and eventual withdrawal over a period of several months if successful outcomes will be achieved.
- All clients who wish to cease methadone should be encouraged to gradually withdraw with the approval and support of the prescribing doctor.
- The sudden withdrawal from methadone while pregnant should be discouraged.

14.1.2 Naltrexone

Naltrexone is an opioid antagonist. Currently available peer reviewed research suggests that naltrexone is only as effective as other treatment options, although its efficacy may be increased when accompanied with ancillary services. There is some limited evidence that naltrexone helps reduce cravings for opioids.

Currently, naltrexone[2] is not listed on the PBS scheme for opiate dependence. The TGA has indicated naltrexone as adjunctive therapy in the maintenance of formerly opioid dependent patients who have ceased the use of opioids such as heroin and morphine. Naltrexone is also used

[1] METHADONE SYRUP® Glaxo Wellcome.
[2] REVIA® Orphan Australia. (Approved at the 200th meeting of the Australian Drug Evaluation Committee 3-4 December 1998.)

by some practitioners for rapid detoxification. It is not registered for this purpose by the TGA. Australian clinical trials are underway.

Naltrexone maintenance treatment is suitable for individuals who:

- are highly motivated to cease using and remain abstinent;
- are socially and psychologically stable;
- have good non using social supports; and
- have a lot to lose if they continue using (such as employed professionals with few criminal charges).

14.1.3 Buprenorphine

Buprenorphine is a strong opioid analgesic with both partial agonist (opioid substitution) and partial antagonist (opioid blocking) properties. Overseas research suggests that buprenorphine is at least as effective as methadone in reducing illicit opioid use and retaining patients in treatment. It may also be useful in detoxification, reducing heroin cravings, and being safer in terms of potential for overdose.

Buprenorphine is not listed on the PBS. A form of buprenorphine has TGA approval for analgesia in Australia.[3] This drug, however, is not approved for use as a treatment drug for opiate dependency. Buprenorphine trials are being conducted across Australia.

14.1.4 LAAM

Levo alpha acetylmethadol (LAAM) is a synthetic opioid analgesic that acts in a very similar way to morphine as it affects the central nervous system. LAAM is not yet available in Australia however, clinical trials are underway in Melbourne. LAAM is not listed on the PBS. LAAM is not approved by the TGA.

14.2 Pharmacotherapies for alcohol dependence

14.2.1 Disulfiram

Disulfiram is a non toxic drug used in the treatment of alcohol dependence. Disulfiram alters the metabolism of alcohol in the body. When alcohol is present in the body, disulfiram will increase the level of acetaldehyde in the body, causing severe discomfort.

Disulfiram is not listed on the PBS. Disulfiram is approved by the TGA.[4] It is indicated as a deterrent to alcohol consumption and as an aid in the overall management of selected chronic alcohol dependent people involved in an integrated program of counselling and psychiatry. Only alcohol dependent people who are motivated to abstain from drinking and who are undergoing psychotherapeutic treatment, ancillary to a total program of rehabilitation, should be selected for disulfiram administration.

There is moderate evidence that disulfiram reduces drinking frequency but no evidence of enhanced abstinence. Supervised disulfiram is more effective than unsupervised disulfiram. Disulfiram is not suitable for people with a range of medical conditions, including heart disease and thyroid disease.

Many clients who have a long standing history of alcohol dependence have a number of associated medical problem. When considering disulfiram, clients should be subject to a thorough medical examination and ongoing medical review.

Disulfiram is suitable for clients who are:

[3] TEMGESIC INJECTION® Reckitt Benckiser.
[4] ANTABUSE® Orphan Australia.

- highly motivated towards abstinence;
- have good non drinking social support networks; and
- have someone (such as a significant other) to encourage and support taking the disulfiram regularly.

14.2.2 Naltrexone

Naltrexone is an effective treatment in reducing cravings, decreasing drinking and reducing relapse. Overseas experience suggests naltrexone is more effective in treating alcohol dependence than opiate dependence.

Naltrexone is listed on the PBS for use within a comprehensive treatment program for alcohol dependence with a goal of maintaining abstinence. Naltrexone is approved by the TGA and is indicated for use within a comprehensive treatment program for alcohol dependence.

Naltrexone treatment may be more effective when used as an adjunct to psychosocial treatments including cognitive behavioural coping skills treatment and supportive therapy. Naltrexone is suitable for clients with high levels of alcohol dependence and cravings or poor cognitive abilities.

14.2.3 Acamprosate

Acamprosate has been demonstrated in clinical trials to be an effective treatment in reducing cravings, decreasing drinking and reducing relapse when combined with a psychosocial program. Treatment outcomes where abstinence is an original goal remain high if treatment continues for one year or longer.

Acamprosate is listed on the PBS for use within a comprehensive treatment program for alcohol dependence with a goal of maintaining abstinence. Acamprosate has been approved by the TGA[5] and is indicated for therapy to maintain abstinence in alcohol dependent patients, to be combined with counselling.

15. Self help groups

The literature regarding self help groups indicates that irrespective of the theoretical orientation of the agency or its counsellors, AA/NA should be considered as a potential service that could be of benefit for some clients.

All clients with inadequate non using/non drinking social support networks, or with high levels of dependence, should be made aware of AA/NA, and if they are willing to consider the goal of abstinence they should be encouraged to attend for at least three visits. All counsellors should be familiar with self help groups in their area.

16. Sobering up centres

Sobering up centres should:

- provide a safe place where an intoxicated person may receive care and respite until the effects of the substances consumed has dissipated;
- offer clients a shower, clean bed, laundering of clothes (worn by the person at admission), and regular observations to ensure that the client is sobering up safely;
- provide clients with a link to further treatment and other health and welfare services when appropriate;
- have the support of local police and other community patrols and health, welfare and community groups for effective operation; and
- be established following a community development process, whereby all local key stakeholders are consulted and included.

[5] CAMPRAL® Alphapharm.

The following is recommended for staff of sobering up centres:

- training in first aid, including recognition of medical conditions requiring hospital referral, management of intoxicated people, critical incidents, and observation procedures; and
- the ability to recognise symptoms of a severe withdrawal syndrome and access medical services if required.

Client populations

17. Coerced clients

The literature indicates similar outcomes are achieved with coerced clients and "voluntary" clients. When working with coerced clients attention should be given to the following.

- Counsellors need to be aware of conflicts of interest between what they perceive to be best for the client and what the referral body requires.
- Counsellors need to be clear as to the limits of confidentiality and the nature of activities that will be reported to the third party. These need to be clearly communicated to the client prior to the onset of therapy.
- Coerced clients may not wish to cease drug use/drinking and therefore counsellors may need to focus initially on harm reduction strategies when working with the client. Harm reduction options should be clarified with the statutory agency.
- Counsellors need to acknowledge resistance and negotiate the relationship accordingly.

18. Incarcerated clients

When working with incarcerated clients attention should be given to the following.

- Counsellors need to be clear regarding to whom they need to report their clients' activities, and need to communicate this to their clients prior to the onset of therapy.
- Counsellors need to be clear as to the limits of confidentiality and the nature of activities that will be reported to the relevant authority. These need to be clearly communicated to the client prior to the onset of therapy.
- Harm reduction should be a strong focus of any intervention.
- Counsellors need to acknowledge resistance and negotiate the relationship accordingly.

19. Partners, families and friends of problem drinkers/drug users

There are two levels of working with this group:

- with parents, partners, families and friends as clients in their own right; and
- with parents, partners, families and friends as part of an individual client's AOD treatment.

19.1 Working with parents, partners, families and friends as clients in their own right

- Parents, partners, families and friends can be clients in their own right, with individual goals and plans.
- Although not the purpose of intervention, working with this group can provide an avenue for the problem drinker/drug user to seek assistance.
- Accurate alcohol and other drug information and support should be provided to this group.

19.2 Working with parents, partners, families and friends as part of an individual client's AOD treatment

- Involving family members is associated with more positive treatment outcomes for the drug user than individual treatment.
- An alternative counsellor to the problem drinker/drug user, if they are the primary client, may be provided as appropriate.
- Counsellors need to be clear about issues of client confidentiality when working with families as often family members, partners or friends make contact regarding the progress of the client.

Counselling should be oriented around (although not limited to) the following:

- assisting the family member to reduce their level of stress and anxiety;
- helping develop interactions that encourage self responsibility and promote positive change in the drinking/drug use behaviour;
- assisting the family member to deal with conflict in relationships; and
- helping the family member develop coping strategies to minimise the negative impact of the substance use on themselves and enhance their quality of life.

19.3 Specific issues for parents

Parent levels of anxiety, depression and grief should be acknowledged prior to providing advice and working on child/parent strategies. It is suggested therefore that interventions with parents initially need to concentrate more on lessening their anxiety and feelings of isolation, and increasing their confidence in managing their situation.

Once these issues have been addressed, work on child/parent strategies can commence. Specific strategies should include:

- providing knowledge of drugs and drug use issues;
- strengthening parenting role and parent's confidence;
- communication skills;
- conflict resolution skills;
- negotiating guidelines/boundaries;
- issues of attachment and commitment; and
- responding versus reacting.

20. Youth

There are a number of important considerations when working with young people. Agencies and counsellors should work from an understanding of the developmental processes that characterise adolescence. These include:

- adjusting to physical changes;
- learning to understand and take responsibility for their sexuality;
- working towards independence from parents;
- developing a sense of identity;
- developing social and working relationships;
- choosing and making career plans;
- being adventurous and experimental;
- needing acceptance from peers;
- not thinking of the long term consequences of their actions, taking risks, feeling immortal;
- being unpredictable in moods and behaviour;
- needing to rebel against the older generation in society;
- being excitable and restless; and
- finding it difficult to talk about feelings.

In addition, research claims that regardless of the family's relationship to the young person's problem, they always need to be involved in the solution, as treatment that does not include the family is less likely to be successful in the long run.

Effective treatment with young people should include:

- taking a holistic and practical approach;
- including the family;
- being flexible in approach, using outreach services;
- providing practical and concrete strategies;
- being aware of other agencies already involved with each client;
- being aware and having the ability to recognise the presence of a comorbid psychological/ psychiatric disorder;
- linking clients to additional medical, psychological or psychiatric services when required; and
- using harm reduction strategies appropriately (see ***Harm reduction***, page 4).

Important counsellor qualities include:

- understanding the developmental processes of adolescence;
- having a sense of humour;
- maintaining consistent limits;
- ability to relate to young people and their parents;
- setting clear boundaries; and
- allowing young people some freedom of choice.

21. Parents/caregivers who have substance use problems

It is essential that assessments of parents who have substance use problems involve the gathering of information about children in their care or those they have access visits with. Many substance using parents may not be able, or willing, to present an accurate picture of the impact of their use and its consequences is having on their children.

Therefore, strategies such as involving children at some point in the counselling process or involving the clients non using partner or other adult support can help to establish the child's situation. It may be necessary, particularly with young children, to refer the family to a service that has the capacity for home visits and intensive support.

When there is any reason to suspect that a child may be at risk of abuse or neglect, it is the counsellor's responsibility to consider statutory intervention. Family and Children's Services can provide confidential consultation.

When working with substance using parents the following is recommended.

- Counsellors make inquiries regarding the family unit and the children's welfare as routine part of assessment.
- Counsellors consider the age of the child as well as short term (physical safety) and long term (comfort, consistency and emotional availability) consequences of parental drug use.
- Counsellors are careful to accurately assess the potential risk of harm to a child when working with a drug using/drinking parent.
- Assessment instruments such as the *Parent Risk Assessment Tool* on the Drugnet website or the *Assessment of Children's Safety Instrument* (in draft) may be useful if a level of suspicion exists.
- Intervention is based on a balance between protection issues for the child and the parent's ability to work towards improving.
- Issues of childcare and risk to children are raised gently and in the context of a supportive therapeutic relationship.

22. Women

When working with women the following is recommended.

- Clients should have the option of a female counsellor.
- Counsellors are sensitive in assessment and handling of issues of sexual abuse and domestic violence.
- Women tend to respond very well if linked to support groups and additional support services.
- Women tend to show better outcomes when participating in women only groups. Where possible, women only groups should be incorporated as part of a group program.
- Programs pay attention to the full range of health (physical and emotional), justice and welfare issues that women may be facing.
- Treatment services assist with the provision of child care where needed.
- Women are offered separate bedroom and bathroom facilities in residential services with mixed gender services.

23. Pregnant women

When working with pregnant women the following is recommended.

- Counsellors remain cognisant of the increased levels of shame and stigmatisation that drug using pregnant women experience.
- Counsellors should not recommend the sudden cessation of any drug use, especially methadone, as withdrawals have the potential to cause miscarriage.
- Counsellors need to facilitate client's engagement with appropriate medical personnel.

24. Men

When initially engaged in a therapeutic relationship, men generally respond well to a cognitive behavioural intervention style. However, treatment should not be limited to this approach. When working with men the following is recommended.

- Counsellors are sensitive in their assessment of issues of past sexual or other abuse.
- Counsellors be aware of the lethality of male suicide attempts and always explore suicidal ideation.
- Where appropriate, men should be encouraged to examine consequences of anger, violence, or domestic violence.
- Where appropriate, intervention incorporate anger management strategies.
- Men are encouraged to examine alternative coping skills to alcohol and other drug use.
- Where possible, men are included in mixed gender groups with women who also choose to be in mixed gender groups.

25. Clients with complex issues

Clients with complex issues are common in alcohol and other drug treatment. When working with this client group the following is recommended.

- Greater attention is paid to personal and social issues beyond drug using *per se*.
- Counsellors liaise with appropriate services, including medical and psychiatric practitioners and social welfare agencies (see ***Case management***, page 5).
- Where appropriate, link clients to additional support services.

26. Clients with co-existing psychiatric issues

Psychological and co-existing psychiatric issues are common in clients presenting for alcohol and other drug treatment. When working with this client group, counsellors the following should be considered.

- Clients presenting for alcohol and drug treatment may exhibit any one of a range of disorders along this continuum, ranging from the less severe (mild anxiety disorders) to the more severe (psychotic collapse).
- It is often difficult to establish the causal connection between substance abuse and psychological and/or psychiatric disorders.
- Psychiatric intervention should be sought for those clients with more complex co-existing psychiatric disorders.
- Liaison with appropriately trained medical and allied health personnel.

27. Sexual abuse

The literature suggests that most often sexual abuse and substance abuse can not be treated as discrete entities but need to be treated together. Counsellors should be careful to establish, and continually re-establish if need be, therapeutic and practical safety with the client.

When working with people who have been sexually abused counsellors should consider the following.

- The need to assess and raise the issue of sexual abuse with sensitivity.
- Post traumatic stress disorder (PTSD) is common among survivors of sexual abuse. Be aware of symptoms associated with the disorder and the functional relationship between substance abuse and PTSD, in order to devise an appropriate treatment plan.
- Referral to appropriate services.
- Brief intervention is not indicated when working with clients who have sexual abuse issues.

28. Cognitive impairment

When working with clients who are cognitively impaired counsellors should consider the following.

- Cognitively impaired clients are given the same respect, rights and privileges as other clients.
- Depending on the degree of severity of suspected cognitive damage, counsellors may wish to refer clients to a clinical or neuro psychologist for further assessment. The purpose of such a referral should be clear to the client and the counsellor.
- Simple and straightforward behavioural type interventions are most appropriate for people with cognitive damage.
- Abstinence is often a more realistic goal than controlled drinking or reduced drug use.

29. Culturally and linguistically diverse

When working with people who are culturally and linguistically diverse the following is recommended.

- Where possible, culturally and linguistically diverse (CALD) clients are given the option of being referred to an appropriate culturally specific service.
- When referral is not possible and the client has a poor understanding of English, with the client's permission, counsellors should enlist the help of an interpreter through the Telephone Interpreter Service. This service can also provide information on the cultural nuances relevant for successful treatment.
- Counsellors use clear and unambiguous language.
- Where appropriate, counsellors consult clients about relevant cultural norms and expectations.

30. Aboriginal people

While Aboriginal people share some common cultural heritage, they are not a homogenous group. Grief is a major consideration when working with Aboriginal people and needs to be considered in

any intervention. Agencies should be aware of the diversity of Aboriginal people and respect different communication styles and cultural nuances that may be likely to influence interventions.

When working with Aboriginal people the following is recommended.

- Counsellors work from an understanding of Aboriginal history.
- Counsellors should be aware of the importance of family (immediate and extended) to Aboriginal people, and include them in all interventions (with the permission of the client).
- Where possible, and with permission from the client, agencies should ascertain the services of an Aboriginal cultural consultant. Preferably this should be someone acceptable to the client who is from the same language group or from the same area. This may include family members, friends or professional services. This is to ensure that interventions are culturally appropriate.

31. Confidentiality

Counsellors have an obligation to refrain from disclosing information received in confidence unless there is a sufficient and compelling reason to do so. Sufficient and compelling reasons include:

- disclosing information about clients during the course of supervision;
- if the client threatens to harm her/ him self or someone else;
- if a child is currently 'at risk' of abuse or neglect; and
- if the counsellor or case notes are subpoenaed to court.

Counsellors should also consider the following in relation to confidentiality.

- Counsellors may also be required to disclose information regarding coerced clients, or clients who are minors.
- Counsellors should be honest regarding the limits of confidentiality prior to any therapeutic engagement.
- Written informed consent should be obtained from clients prior to an agency (or counsellor) sharing any client related information with associated professionals or otherwise.
- When sharing information about clients, counsellors should consider the possible lack of confidentiality when faxing information.
- Under the Commonwealth *Freedom of Information Act 1982* and the Western Australian *Freedom of Information Act 1992* clients can apply to have access to their own case notes and assessment information.

32. Supervision and professional development

Supervision and professional development is an important aspect of any treatment service as it assists in the maintenance and improvement of counsellors' standard of practice.

Professional development can include both self directed and agency facilitated learning. Individual and whole of agency approaches should complement each other. Indicators include the following.

- On the job learning, including regular clinical supervision for all counselling staff by experienced clinicians. In addition, peer supervision (or coaching) may also be used.

- Particular skill development should be sought when working with the following client groups:

    - clients with a history of sexual abuse;
    - clients with cognitive impairment; and
    - clients with complex issues.

- Incorporation of action learning and coaching methodologies.

- *Action learning* is a simple but disciplined method using an ongoing cycle of plan - act - review to achieve personal, professional and organisational goals. It uses on the job evidence on which learning and improved practice is developed, through a variety of skill development strategies.
- *Coaching* is a process that helps improve individual or team performance with an emphasis on learning, structured questioning and ongoing support.

- Tailored professional development and training to suit the individual and group needs of staff, which incorporates the nature of their job and experience and followed up with workplace integration.

- On the job learning and resources, such as videos, journals, web sites and books are easily accessible by staff who have scheduled time for this purpose.

- Opportunistic learning such as case discussions, informal dissemination of new information and impromptu presentations are features of a learning workplace.

- Individual and agency gains from the professional development program are acknowledged and made explicit.

33. Quality assurance

Specific indicators for quality assurance include the following.

- The examination of a case file, chosen at random, by the clinical supervisor to ensure quality of record keeping and apparent quality of practice. This process should provide the counsellor with feedback regarding quality of practice and possible methods for improving level of practice.
- Regular clinical supervision, including peer and other professional development should be provided for all staff.
- Senior staff should provide advice and guidance in relation to evidenced based practice.
- Clients should complete client satisfaction surveys routinely.

34. Best practice outcome performance indicators

Core performance indicators involve changes in scores on measures of a number of key areas of client functioning from the beginning to the end of treatment, and at follow up at one or three months after treatment (where possible). The assessment of client satisfaction is also a core performance indicator.

Core performance indicators, to be reported for all clients, are as follows:

- reduction in alcohol and/or other drug;
- reduction in overdose risk and blood borne disease risk behaviours;
- improvement in social functioning;
- improvement in physical health;
- improvement in psychological adjustment;
- reduction in criminal behaviour; and
- client satisfaction assessment.